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15 – Tackling Health Inequalities: the Role of Family Medicine

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The late Barbara Starfield left us her wisdom, “Inequity is built into health systems- especially health systems that are based on a view of health needs disease by disease. Therefore, the benefits of primary care, which is in person- and population- rather than disease-focused, are under-appreciated. Data provide evidence not only of its benefit to populations but also of its preferential benefit to the socially disadvantaged.” (1)

Introduction

Health inequities occur in different socio-economic classes (2), and span across a wide range of socio-cultural characteristics (2-3). Health inequity refers to differences in health that are not only unnecessary and avoidable, but are also unfair and unjust (4). Research consistently shows that gaps in health and health care persist, and are even widening (5). Research has repeatedly shown the strength of a country's primary health care system and its primary care attributes significantly improves populations' health and reduces inequity (6-7). Starfield *et al* identified the primary care attributes that contribute to population health, including first contact access, greater focus on prevention, provision of person-focused comprehensive care, with greater continuity and coordination (7). Such attributes are of special importance to inequity reduction as the socially disadvantaged have a greater likelihood of occurrence, severity, and adverse effects in multiple illnesses for which a comprehensive, coordinated, person-focused primary care (rather than a speciality driven, disease-focused) view of morbidity can be more effective (1).

Recent evidence also supports the above conclusions showing that primary care can reduce inequity in developed as well as in low and middle-income countries. A review that assessed the contribution of large primary care initiatives to a broad range of health system goals in low and middle-income countries concluded that primary care-focused health initiatives had improved access to health care, including among the poor, at reasonably low cost and primary care programs had reduced child mortality and, in some cases, wealth-based inequity in mortality (8).

Current Health Inequity Issues Faced by Primary Care Practitioners (PCP)

As a foundation step for the establishment of WONCA's first Health Equity Special Interest Group, The World WONCA held a workshop on health equity during its bi-annual meeting in Prague on 26-30 June 2013 with the aim of exploring how a better understanding of health inequities could enable PCP to adopt strategies that could improve health outcomes through the delivery of primary health care. It was

attended by 120 delegates from across the globe, including developed as well as low and middle-income countries. Following the presentations, workshop attendees were asked to participate in small group discussions and were asked to rate on thirteen possible inequity reduction activities on a 1-5 Likert scale in an anonymous survey.

In the small group discussions, they recognized in their own setting how uneven distribution of social determinants of health could have affected poor health outcomes such as life expectancies and risk behaviours, and how health systems that had operated in different countries could have systematically affected people's affordability as well as access to healthcare services and fundamental rights to good health. They identified health workforce shortage, lack of communications between primary & secondary care, low political incentive and priority for marginalized populations as well as low health literacy and expectation of the patients as contributions in meeting the health equity agenda. They believed signposting for how to navigate the healthcare system and training should be provided to leaders of vulnerable groups since community awareness should be provided to the public as well as the patients. Furthermore, they believed that training in inequity should be provided to medical students as well as PCP on how to improve health equity through primary care.

Overall, the participants rated the degree to which their country currently had utilized the various mechanisms to reduce health inequity as "moderate" (mean: 2.85, standard deviation (SD): 1.12). The results indicated that the types of mechanisms most commonly utilized included: promoting access to primary care (mean: 3.63, SD: 1.24); initiation of public health programs to promote health equity (mean: 3.17, SD: 1.01); and, promoting access to care by increasing coverage (mean: 3.12, SD: 1.36). The activities least practised were: engagement in cross-national collaborations to promote health equity (mean: 2.12, SD: 0.99); promoting research on health equity (mean: 2.40, SD: 1.04); and, reforming medical education to incorporate health equity and cultural competency training (mean: 2.44, SD: 0.96).

On average, participants rated the degree to which they had believed the items representing priority areas which countries should be engaged in as "high" (average: 3.85, SD: 0.88). Practices most commonly viewed as useful were: promoting the availability of primary care services (mean: 4.68, SD: 0.63); and, initiation of primary care programs to promote health equity (mean: 4.42, SD: 0.76).

How Could PCP Help in this Movement?

In view of these findings and enthusiasm within the profession, the Health Equity Special interest group (SIG) was proposed and approved by the WONCA Executive in early 2014 bringing the essential experience, skills and perspective of interested PCP around the world to address the differences in healthcare that are unfair, unjust, unnecessary but avoidable. It is hoped this group will use WONCA as a platform for exchange of ideas, advice, support and advocate for better equity in health.

The WONCA Health Equity SIG plans to contact and work with existing centres on health equity; to provide news updates and events related to health equity; to conduct/facilitate literature review on research gaps; to collaborate/identify/set up a resource centre on health equity; to organise regional/international workshops/ seminars to keep up with the health equity agenda; and, to formulate a framework within a medical curriculum on health equity. Interested parties should visit:

<http://www.globalfamilydoctor.com/groups/SpecialInterestGroups/HealthEquity.aspx> for further information.

Take Home Messages

- Despite evidence of the contribution of the core attributes of primary care to populations' health and reduction of inequity, inconsistencies are found in implementation of primary care features in different countries, with greater emphasis on the provision of easily accessible primary care and less investment in promoting programmes to improve continuity or coordination.
- Health equity workshop participants expressed similar assessments regarding their countries' priorities, indicating that promoting access (availability and coverage) of primary care services was more often performed than initiating tailored primary care interventions (mean score: 3.04-3.63, compared to 2.96, respectively).
- Importantly, survey respondents identified "promoting access to primary care services" as the most important

priority that countries should engage in.

- Activities that have been previously cited as important for promoting equity in health i.e., reform in medical education, promoting research, and fostering cross-national collaborations, were identified by survey respondents as low current priorities in their own countries.
- Assessment of the gaps between current and preferred priorities showed that to bridge expectations and actual performance, countries should engage in forming cross-national collaborations; incorporate health equity and cultural competency training in medical education; and, engage in initiation of advocacy programs that involve major stakeholders in equity promotion policy making as well as promoting research on health equity.

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Original Abstract

<http://www.woncaeurope.org/content/28-tackling-health-inequalities-role-general-practice>

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	The level to which this activity is currently part of respondent's countries' key priority issues (1-5)*, M±SD	The level to which this activity SHOULD be part of respondent's countries' key priority issues (1-5)**, M±SD
Initiation of advocacy programmes to involve major stakeholders in equity promotion policy making	2.71±1.08	4.35±0.75
Reform of medical education to incorporate health equity and cultural competency training	2.44±0.96	4.19±0.83
Promote research on health equity	2.40±1.04	3.96±0.85
Initiate public health programmes to promote health equity	3.17±1.01	4.22±0.89
Initiate primary care programmes to promote health equity	2.96±1.04	4.42±0.76
Promote access to care – availability of primary care services	3.63±1.24	4.68±0.63
Promote access to care- increased coverage of services / health insurance	3.12±1.36	4.20±1.12
Promote access to care- point-of- service free care	3.04±1.06	4.08±1.08
Promote the collection of socio-demographic data on patients in a routine and standardized way	3.07±1.46	3.82±1.31
Write guidelines for physicians for health equity promotion	2.70±1.23	3.74±1.13
Promote the development and implementation of tools to measure and monitor inequity in health	2.73±1.12	4.11±0.70
Promote diversity in medical workforce	2.96±1.19	4.04±0.84
Engage in cross-national collaborations to promote health equity	2.12±0.99	4.08±0.91

*1=Currently **not** a priority; 5=Currently a **top** priority.

1=SHOULD **not be a priority; 5=SHOULD be a **top** priority